BACKGROUNDER: FUNCTIONAL BARGAINING UNITS IN ALBERTA'S HEALTH CARE INDUSTRY

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The division of health care workforces into standard, functional bargaining units has been a feature of health care labour relations in Alberta for over two decades. After industry consultation and a series of cases, the Alberta Labour Relations Board communicated to the industry in its *Information Bulletin No. 4* (1977) that as a matter of policy it would normally certify only one of five standard bargaining units in the hospital industry. It also indicated that these units would be described in "functional" terms -- based on what broad work functions employees were actually called on to perform -- rather than terms based on job classifications or educational qualifications. In 1982, after industry consultation, it also adopted a policy of certifying three standard functional bargaining units in community health: see *Information Bulletin 9-82*. These policies have, with the rarest of exceptions, been followed to this day.

Much has changed since 1977. New health disciplines have emerged. The pace of technology has altered the composition of the workforce and the way in which many employees do their jobs. Spiralling health care costs and government funding cutbacks have forced health care employers to examine new ways of delivering services. And now, with the regionalization of health care, new governing bodies have been established to assume both hospital and community health functions, with a broad mandate to reorganize health care delivery systems.

In its 1994 Transitional Bulletin T-2, the Labour Relations Board said of its functional bargaining unit policy:

The Board recognizes that health care practice may undergo major change as a result of regionalization. The Government has also indicated an interest in reviewing exclusive scope of practice issues in its health professions legislation. The Board will follow these developments closely. If it finds occupational groups are changing significantly, it may re-evaluate its health care bargaining unit policies. At this point such re-evaluation would be premature because industry practice can be expected to evolve substantially over the next while as parties adapt to regionalization. Industry consultation will precede any major change in the Board's bargaining unit policies.

This paper is intended as background material for a discussion on whether developments in health care point toward a re-evaluation of the Board's functional bargaining unit policy. It briefly outlines the policy and some of the factors that have historically supported the Board's division into five (or three) standard units. It notes the practice of some other jurisdictions in fashioning health care bargaining units. Finally, it notes some developments in the industry that arguably affect the functional bargaining unit policy and raises for discussion some questions that a thorough review of the policy might have to address. As for the other backgrounders, a bibliography directs readers to some useful sources on the topic.

Origins of the Functional Unit Policy

The policy of certifying bargaining agents for one of five standard, functionally-described bargaining units in the hospital industry developed between 1972 and 1977. Several processes contributed toward this policy:

"Craft-style" organizing in the hospital sector.

One notable aspect of Alberta's health care labour relations history prior to 1972 was the predominance of craft-style, occupationally-based organizing -- and the almost complete lack of broad, industrial-style bargaining units. The earliest incursions of organized labour into the Alberta hospital system occurred among the trades employees in the hospital physical plant. Typically these were Operating Engineers certifications for small units of steam engineers. There were also a significant number of early certifications, usually of the Canadian Union of Public Employees, for portions of what is now the general support services bargaining unit. Unsurprisingly, during this initial stage of organizing in the sector, unions sought certification for the employee classifications where they enjoyed at least some level of support, and the (then) Board of Industrial Relations generally granted certification without any concern that other support classifications would be excluded from the certificate. The result was a patchwork of bargaining relationships, set out in long bargaining unit descriptions that used the occupational classifications of the individual hospital.

At the other end of the hospital workforce spectrum, craft-style organizing developed out of occupationally-based professional associations. By the nature of nursing and the common training, licensure and code of conduct imposed by the status of registered nurse, RNs possessed a natural community of interest that resulted in an appetite for collective bargaining as an occupational group. When nurses organized, they organized in associations and trade unions limited to nurses. This pattern Alberta shared with all other Canadian jurisdictions. Where Alberta seems to have diverged, however, is that nursing aides also at an early stage started to self-organize in occupationally-based units. The Alberta Certified Nursing Aides Association (later AARNA and then the Canadian Health Care Guild) sought to represent units restricted to certified nursing aides as early as 1957, a pattern that persisted into the 1970s. There seems to have been no significant successes by any industrial-type union in organizing nursing aides during this time.

The final building block in this craft-style bargaining structure was the establishment of the Health Sciences Association of Alberta in the early 1970s, with a mandate to organize paramedical health workers. This significant and growing block of employees had for the most part been ignored by the other unions, and HSAA was so clearly identified as the vehicle for this group to acquire collective representation that, again, no other union achieved significant organizing success within the group.

This predominance of craft-style organizing by unions who saw their mandate as that of organizing specific occupational groups was probably reinforced by the concept of the "proper bargaining agent". Until 1980, Alberta's Labour Act required that the Board certify a union only if it were satisfied the union was a "proper bargaining agent". This meant that the union had to be constitutionally capable of representing the employees in question. Any union that had a restricted mandate to organize only certain occupational groups found it difficult to organize other employees without making a fundamental change to its constitution. Once started, then, the practice of organizing by occupational groups tended to be locked in by statute as well as by the natural inclinations of the trade union and employees.

It should be noted that one other union, the Alberta Union of Provincial Employees, has a major presence in health care because of its history of representing provincial government hospital employees. It acquired most of its bargaining rights under the Public Service Employee Relations Act, although the Public Service Employee Relations Board's early adoption of the Labour Relations Board's five functional units resulted in an almost identical bargaining structure in the provincial hospitals. Alone of the major health care unions, AUPE represents

employees in all of the Board's functional groups.

Increasing Union Density in the Hospital Sector

In common with other Canadian jurisdictions, union density in the hospital sector increased dramatically in the 1960s and early 1970s. Many more hospitals became at least partly organized, and many more hospitals, especially in the urban centres, employed workforces in which every major occupational group had or sought collective representation. The result was increased skirmishing between unions, and between employer and union, over bargaining unit boundaries. Increasing union density in individual hospitals also raised the prospect that small pockets of unorganized employees would be excluded from every bargaining unit and marooned in "tag-end" groups with no recourse to effective collective bargaining.

Proliferating Job Classifications

Advances in medical technology throughout the 1960s and 1970s resulted in many new diagnostic tests and modes of treatment, together with entirely new classifications of employees to administer them. This was especially so in the paramedical occupations. At the same time, occupational terminology in hospitals became less uniform and a less reliable indicator of what the employee actually did. One sees in the few written health care decisions of the Board during this time an increasing frustration with job classification terminology as a reliable basis for describing bargaining units.

Human Rights Legislation

Finally, the practice of differentiating between employee groups by job classification terminology came under attack from another direction in the early 1970s. An "equal pay" complaint under Alberta's *Individual Rights Protection Act* resulted in the important case of *Gares v. Royal Alexandra Hospital* (1976) 76 C.L.L.C. 14,016 . In that case the late Justice D.C. McDonald held that it was unlawful discrimination to pay members of the female-dominated nursing aide classification less than members of the male-dominated nursing orderly classification when they performed essentially the same functions. The decision pointed out in stark terms the importance of basing collective bargaining on job function rather than occupational terminology.

The first steps toward a comprehensive solution to hospital bargaining units took place in 1972. The Health Sciences Association was in its infancy then, and in one of its first certification applications the Board had to examine the appropriateness of a bargaining unit encompassing all the paramedical classifications. In *Health Sciences Association of Alberta v. Misericordia Hospital* (Alta. L.R.B. No. 72-024, Nov. 28, 1972, D'Esterre, Chair), the Board rejected the comprehensive paramedical unit. It amended the unit to exclude the classifications of dietician, medical social worker, hospital pharmacist, occupational therapists, physiotherapists, laboratory scientist and medical psychologist. It referred in its reasons to the excluded employees as a "paramedical professional" group and the amended unit as a "paramedical technical" unit. Although it noted that the dividing line between the two groups was that the professionals were generally required to have a formal university training, the reason for excluding them was not that they lacked community of interest with the technicals, but that the professionals were solidly against collective representation. The Board was of the view that but for their opposition to collective bargaining, paramedical professionals might well be appropriately included with the technicals in a composite paramedical unit. The Board added that a separate "paramedical professional" unit might also be appropriate. Finally, it signalled its intention to make the paramedical technical unit one of general application:

The Board recognizes that the unit determined as appropriate for collective bargaining will not be absolute for all hospitals. It does, however, establish initial guide lines to be considered by trade unions when applying to represent hospital employees. (...)

The Board is aware that other hospitals may employ additional classifications of "technical paramedical employees" that are not described in the unit determined as appropriate respecting this application. Furthermore, as medical technology develops new paramedical classifications are likely to be established. When this occurs, the Board may find it necessary to determine the placement of additional or new classifications.

In 1975 the Board took the next step by signalling a departure from its previous practice of certifying for narrower, qualification-based units such as "certified nursing aides", and towards the use of broader functional language. In *Alberta Certified Nursing Aide Association v. Bethany Auxiliary Hospital* (Alta. L.R.B. 75-032, July 26, 1975, D'Esterre, Chair) it rejected a "certified nursing aides" bargaining unit and indicated that it would require other auxiliary care employees performing direct patient care to be included with the nursing aides:

The Board is also aware that within the auxiliary direct patient care field in the hospital industry there are many classifications with their related occupational terminology. Usage of the terminology varies considerably from hospital to hospital. As a result, in the opinion of the Board, *the focus on unit determination must centre on the function of the unit as it relates to its functional contribution to the hospital in question and not on the ambiguous and uncertain occupational terminology used.* It is the opinion of this Board that in the field of auxiliary direct patient care, the unit would be comprised of all employees of the employer providing a direct auxiliary nursing patient care regardless of the title of the classification used. (Emphasis added)

The Board enforced the new auxiliary nursing care unit through several decisions, dismissing ACNAA applications for a unit restricted to certified nursing aides, and dismissing CUPE applications to be certified for expanded support units that included the unrepresented fragments of the new standard unit: e.g., *CUPE, Loc. 189 v. Medicine Hat General Hospital* (Alta. L.R.B. 76-017, March 12, 1976, Williams, Acting Chair).

The last element of a comprehensive standard bargaining unit policy in the hospital industry was to standardize units in hospitals' general support services. In *CUPE, Loc. 41 v. Misericordia Hospital* (Alta. L.R.B. 76-028, June 4, 1976, Laird, Acting Chair) the Board amended CUPE's sought-for bargaining unit to one including "All employees when employed in general support services". This description was interpreted to include steam engineers, effectively decertifying the Operating Engineers for a small trades unit it had held for some time. The unit description quickly became the Board's standard description and put an end to the long practice of organizing craft units of tradespersons in hospitals' physical plant.

Therefore, by 1976 the Board had identified the five standard functional hospital bargaining units that exist today: direct nursing care, auxiliary nursing care, paramedical professional, paramedical technical and general support services. See, e.g. *HSAA v. Mineral Springs Hospital* (Alta. L.R.B. 76-024, June 8, 1976, Laird, Acting Chair). The new policy was publicized in the Board's Information Bulletin No. 4 in 1977.

In succeeding years the Board gradually brought existing bargaining units into line with the "five functional units" policy. Occasionally this happened through a straight reconsideration of an employer's certificates: e.g., *Metro-Calgary and Rural General Hospital District No. 93 v. ACNAA et al* (Alta.L.R.B. 76-031, June 10, 1976). Sometimes it was accomplished by an application to sweep in unrepresented employees into a non-standard unit, which the Board refused to grant unless all the unrepresented employees in the standard unit were brought under the certificate. Many units were standardized when rural hospitals were reorganized into hospital districts. The Board routinely recognized the district as the employer and amended the certificates to the standard unit descriptions. Finally, the Board allowed partial raids where the application would carve out a standard unit from an anomalous bargaining structure: *AARNA v. Smoky Lake General and Auxiliary Hospital and Nursing Home District No. 73* [1986] Alta. L.R.B.R. 472.

The five functional units fashioned by the Labour Relations Board were adopted as appropriate units in the provincial hospitals at an early stage by the Public Service Employee Relations Board:

The result of the early adoption and strict adherence to the five functional unit policy is that there is a remarkable uniformity to hospital bargaining units in Alberta. There are only a handful of non-conforming certificates. For example, about six Operating Engineers certificates for stationary engineers survived through to 1994.

Most observers would likely say that the five functional unit policy has benefitted both organizing and collective bargaining in the hospital industry: organizing because unions know exactly which employees to organize, and collective bargaining because the uniformity of bargaining units across the province has allowed province-wide bargaining to flourish.

The bargaining units themselves have proved remarkably stable, at least until the regionalization process. In 1986 the Board undertook a limited review of the five functional units: *UNA, Local 51 et al. v. Alberta Hospital Association et al.* [1986] Alta. L.R.B.R. 610. It was prompted by an unusually high number of contested determination applications, suggesting that there might be problems with the standard wording of the units. An invitation to raise any such problems, however, produced only one response, a request by the United Nurses of Alberta to amend the standard nursing unit to cover qualified nurses working at tasks other than direct patient care that nevertheless qualified as "nursing" for purposes of continued registration. The Board rejected the request as subversive of the functional nature of the standard units.

Practice in other Jurisdictions

Other jurisdictions have not experienced a hospital labour relations history like Alberta's. In particular, they have not experienced the predominance of "craft-type" unions (for want of a better term) like the Canadian Health Care Guild for auxiliary nursing employees and the Health Sciences Association for paramedical employees. In many jurisdictions some of these employees have been organized on a broader basis by industrial-type unions like CUPE, the Service Employees International Union, or (in B.C.) the Health Employees Union. In these jurisdictions, then, the "craft" has not been the dominant consideration in defining employees' community of interest and other communities of interest have been defined. To review just a few of these other jurisdictions:

Ontario:

Ontario has a long history of non-standard units and many anomalous units . Such uniformity as there is has been shaped by agreement between hospitals and unions over the shape of the bargaining unit and a relatively few leading Board pronouncements on what constitutes an appropriate bargaining unit, which generate reliance by unions on those bargaining units. Units in Ontario tend to fall into these descriptions: nursing; paramedical (combined technical and professional); service (including RNAs, nursing assistants and the trades) and office and clerical. See *Stratford General Hospital* [1976] O.L.R.B. Rep. Sept. 459, where the Board determined that a combined paramedical-professional and paramedical-technical unit was the appropriate unit; and *Hospital for Sick Children* [1985] O.L.R.B. Rep. Feb. 266, where the Board discussed in detail the scope of an appropriate "service" unit in a large teaching hospital.

British Columbia:

B.C. bargaining unit practice has been heavily influenced by the B.C. Labour Relations Board's historical preference for large, industrial-style units and by the broad organizing practices of the Health Employees Union (HEU). There as here, the first certifications in the industry were among stationary engineers and other skilled tradespersons, usually represented by the Operating Engineers, and among registered nurses. The HEU developed the practice of certifying for all other employees. In practice, however, it underbargained these certificates to exclude the paramedical professional classifications where there was antipathy to collective bargaining. In the early 1970s the Health Sciences Association of B.C. (HSA) was formed to represent paramedical professionals. In view of the history of underbargaining, the B.C. Board adopted the practice of carving out paramedical professional units from the HEU all-employee certificates. It refused, however, to extend the HSA bargaining units to the paramedical technical

classifications: *HEU, Loc. 180 v. HSA and Kelowna Hospital Society* [1977] 2 Can. L.R.B.R. 58. At the same time, for "compelling historical reasons" it allowed existing trades units to survive (*HEU, Loc. 180 v. Cariboo Memorial Hospital* [1974] 1 Can. L.R.B.R. 418), though it refused to grant new certifications for craft units. The pattern of bargaining units in B.C. prior to the recent work of the Health Sector Labour Relations Commission, then, was: nurses; paramedical professionals; and all other employees, typically including nursing aides, paramedical technicals, office and clericals, housekeeping and laundry, and tradespersons.

These functional divisions in the acute care sector were preserved by Commissioner James Dorsey in the report of the Health Sector Labour Relations Commission in 1995. His report, and the Regulations passed to implement it, effectively eliminated the anomalous trades-only units preserved in *Cariboo Memorial Hospital*. The report also eliminated the divisions between acute care, long term care, community health and mental health operations for nurses and paramedical professionals, though not entirely for support employees. The report and Regulations establish five province-wide bargaining units of residents; registered and graduate nurses; paramedical professionals; health services and support --facilities; and health services and support -- community.

Saskatchewan:

The Saskatchewan experience has been largely one of carving out smaller units from established "all employees" units. Hospitals in Saskatchewan were in many cases organized "wall-to-wall" by either the SEIU or CUPE at an early date. Nurses were the first group of employees to seek a carve-out, and were generally successful because of their licensure, training, membership in professional associations and sheer numbers. The Health Sciences Association of Saskatchewan emerged in the 1970s to represent the interests of employees in the paramedical classifications. Since then it has sought certifications for paramedical units, usually against the opposition of the incumbent industrial union, with varying success. The Saskatchewan Board first recognized carved-out units of paramedical professional employees in the large urban hospitals: e.g., *HSAS v. University Hospital* (1973) Sask. L.R.B. File No. 017-73. Paramedical professionals were considered to possess a compelling community of interest, and a significant number of these bargaining units exist today. From 1981 the Board occasionally carved out units of paramedical technical employees in the larger hospitals. These units, however, have been much less common, and generally paramedical units have not been carved out at all in the rural hospitals, where the normal unit is still "all employees except nurses".

Recent decisions of the Saskatchewan Board demonstrate both a reluctance to fashion standard bargaining units and a reluctance to diminish the broad SEIU and CUPE units any further except for compelling reasons. The Board has been willing to make exceptions where the carved-out unit is large and where there is a history of non-representation or substandard representation of the employees seeking a carve-out, but not otherwise. See, e.g., *HSAS v. Wascana Rehabilitation Centre* (1994) Sask. L.R.B. File No. 265-93.

Newfoundland:

Newfoundland's health bargaining structures come closest to Alberta's in terms of standardization. There, by Board practice there are four bargaining units in the hospitals: nurses; allied health professionals (roughly corresponding to our paramedical professional unit); laboratory and x-ray technicians (comprising some but not all the classifications in our paramedical technical unit); and support staff, which includes nursing aides and assistants, the trades, food service, laundry, and so on.

United States:

After a long history of case-by-case adjudication of bargaining units in the acute care hospitals, and much duplicative litigation, the National Labor Relations Board prospectively standardized its bargaining units by use of its rulemaking power. After extensive public hearings and submissions, in 1989 the NLRB adopted a Final Rule recognizing eight appropriate bargaining

units. Excluding physicians and security guards, the NLRB standard units are now:

- nurses;
- all professionals except nurses and physicians (roughly our paramedical professional unit);
- all technical employees (roughly our paramedical technical unit);
- all skilled maintenance employees;
- all business office clerical employees; and
- all other nonprofessional employees (our support unit, less the trades and office clericals).

The Final Rule maintains existing non-conforming units, but mandates that applications to add new employees must conform to the standard units. It also recognizes an exception where a standard bargaining unit would contain five or fewer employees, in which case the Board is to decide the appropriate units by adjudication. See NLRB *Final Rule on Collective Bargaining Units in the Health Care Industry*, Federal Register Vol. 54, No. 76, April 21, 1989; NLRB *Second Notice of Proposed Rulemaking on Collective-bargaining Units in the Health Care Industry*, Federal Register Vol. 53, No. 170, Sept. 1, 1988.

Industry Developments

As stable as the five functional units have proven to be, there have been developments in the industry in the last decade that arguably might warrant a re-examination of the five functional units. They include:

Proliferation of health disciplines and convergence of professional and technical classifications. Prior to adoption of the functional bargaining unit policy, the only employee groups of any size with a claim to professional or quasi-professional status were nurses and certified nursing aides. This status, and employees' membership in professional organizations that licensed and regulated them, formed the basis for the occupational bargaining units that later became the standard direct nursing and auxiliary nursing units. The paramedical professional unit evolved as a grouping of the several small occupational classifications that required university training and associated in occupational associations. These classifications were separated from the paramedical technical classifications, which by and large acquired training on the job and did not have occupational associations.

Starting in the 1970s and accelerating into the 1980s, there has been a process of "credentialization" of the technical classifications. Technical training has moved solidly into the community colleges and technical institutes. Common training has enabled objective standards to develop for certifying competence. Occupational associations have emerged for many of the technical classifications, and under the umbrella of the *Health Disciplines Act* some of these associations have taken over the role of certifying competence and enforcing occupational standards. There are now regulations under the *Health Disciplines Act* "professionalizing" x-ray technicians, medical laboratory technologists, medical radiation technologists, respiratory technologists, emergency medical technicians, psychiatric nurses, and midwives.

Increased organization of paramedical professionals. It seems quite clear from the early cases that the main reason the Board did not allow combined paramedical technical - paramedical professional units is that the professional classifications did not want any part of collective bargaining. This appears to have been typical of the professional classifications at the time. Although the professional classifications have been slower to organize and to this day many more pockets of professional employees than technical employees remain unorganized, the professionals' antipathy to collective bargaining has largely vanished. It can no longer be assumed either that including professionals in a paramedical unit creates a barrier to organizing, or that professionals would be swept into such a combined unit against their will.

Changing roles of nurses and auxiliary nursing employees. Though nurses retain a monopoly

over those aspects of direct patient care that are within their exclusive scope of practice as set out in the *Nursing Profession Act*, other aspects of their jobs have been increasingly allocated to auxiliary nursing employees. Often groups of nurses have been replaced by LPNs supervised by a small number of nurses. This has been a widespread response to provincial funding cutbacks: hospitals adopt a leaner "mix" of nurses and LPNs, lay off nurses, and give more supervisory responsibilities over the team to the nurses that remain.

Nurses and auxiliary nursing employees have always shared a certain community of interest through their joint responsibility for direct, hands-on patient care. That community of interest has been overshadowed in Alberta (and everywhere else) by nurses' long history of bargaining as an occupational group and their exclusive scope of practice. If nurses' exclusive scope of practice is significantly narrowed -- though there has been no serious move in this direction yet -- it is possible the argument could be made that not enough functional differences will remain between the groups to maintain the separate bargaining units in view of their daily co-operation and joint responsibility for direct patient care.

Regionalization and reorganization of health care. Regionalization is just the administrative first step toward reorganization of health care delivery. We can expect to see an end to the more-or-less rigid division between hospital and community health services, and a transformation of the hospital from a totally self-contained worksite to the hub of a network of inpatient and outpatient services delivered by a mixture of hospital, community health, not-for-profit, and for-profit health workers. Depending on the means that individual regions adopt, we may see much closer co-operation between hospital and community health employees in the future. That in turn can be expected to create demand for greater lateral mobility between hospital and community health positions, which would be frustrated by significantly different bargaining unit structures. Transitional Bulletin T-2 stated that where hospital and community health units are integrated in a regional structure, the Board would initially favour converting the three community health units into five, to match the standard hospital units. This is an interim solution, and whether it is the best long-term solution is not clear. To date there has been no case before the Board in which there has been sufficient integration between hospital and community health employees to warrant redistributing the latter: see, e.g. *HSAA et al. v. Chinook Regional Health Authority et al.* (As yet unreported Alta. L.R.B. Decision, July 25, 1996).

Standard Functional Bargaining Units Questions to Ponder

1. Do the current functional units (5 in hospitals - 3 in community health) continue to work?
2. How can one describe the business as it currently operates in health care and further, how can one describe the functions of employees within that business?
3. What are the difficulties/challenges/circumstances arising which test the usefulness of these units?
4. What benefits arise for employees/unions/employers in maintaining these units?
5. What external factors exist or will exist which would make these units unworkable?
6. How is collective bargaining enhanced/challenged by the use of standard functional units?
7. Is there any case to be made for combining the nurses unit with the auxiliary nursing care unit into one, on the basis that the groups share a community of interest as direct patient care providers? Whatever might be said in favour, though, bargaining history is strongly against this option; both groups have a long and effective history as occupational bargaining units. Is the history decisive?
8. Why did Alberta not follow the practice in other Canadian provinces of treating employees in auxiliary nursing care as part of the general support unit? Is it an historical anomaly without any current basis in policy other than the weight of history? Or was Alberta the first and (apparently) only jurisdiction to recognize a unique auxiliary nursing care community of interest? And does it matter any more? Is the history of separate auxiliary nursing care representation so well-established that any change is just not a sensible option?

9. Is there a policy basis for merging paramedical professional and paramedical technical units into one, considering that typically the same union, HSAA, represents both groups and so bargaining history would not be a factor? Would merging the units have any real effect? Do seniority "districts" exist among paramedicals not because of bargaining unit boundaries, but because of the training and qualifications that each classification must have?
10. Should the Board ever again contemplate carving out trades units from the general support unit? Is there any serious continuing tension between trades employees and office and clerical employees in the general support unit that might be solved by creating separate units? The U.S. National Labor Relations Board rule on bargaining units supports this option. Or on the other hand, would this be an unwise reversal of course for this Board, which has strongly opposed the carving out of craft units from broader industrial bargaining structures, especially in health care?
11. What improvements in labour relations would arise from changes to the units?
12. What process should the Board use to solicit input on changes to these units, if necessary?

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HomePage